		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038570

Facility Name: Shelbyville Manor

Address: Route 128 North (Number) Shelbyville (City) 62565 (Zip Code)

County: Shelby

Telephone Number: (217) 774-2111 **Fax #** (217) 774-2209

IDPA ID Number: 37-1223745006

Date of Initial License for Current Owners: 09/01/80

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Ron Wilson
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Independent Accountant's Report (Date)
(Print Name and Title) McGladrey & Pullen, LLP
(Firm Name & Address) 117 East Main, Suite 210, P.O. Box 1070, Galesburg, Illinois 61402
(Telephone) (309) 342-1175 Fax # (309) 342-7816

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,815	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	131	TOTALS	131	47,815	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,271	5,100	2,712	14,083	8
9	SNF/PED					9
10	ICF	12,543	10,543	0	23,086	10
11	ICF/DD					11
12	SC			0		12
13	DD 16 OR LESS					13
14	TOTALS	18,814	15,643	2,712	37,169	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.74%

D. How many bed-hold days during this year were paid by Public Aid?
8 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 12/01/92

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 08/25/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 13 and days of care provided 2,712

Medicare Intermediary AdminaStar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	163,709	17,406	6,600	187,715		187,715		187,715			1
2	Food Purchase		170,745		170,745		170,745	(3,036)	167,709			2
3	Housekeeping	91,165	22,113	31	113,309		113,309		113,309			3
4	Laundry	48,123	13,553		61,676		61,676		61,676			4
5	Heat and Other Utilities			95,482	95,482		95,482	325	95,807			5
6	Maintenance	30,705	17,053	28,570	76,328		76,328	467	76,795			6
7	Other (specify):*											7
8	**TOTAL General Services**	333,702	240,870	130,683	705,255		705,255	(2,244)	703,011			8
	B. Health Care and Programs											
9	Medical Director			10,900	10,900		10,900		10,900			9
10	Nursing and Medical Records	1,312,395	130,165	3,030	1,445,590		1,445,590		1,445,590			10
10a	Therapy	108,773		9,228	118,001		118,001		118,001			10a
11	Activities	56,397	1,831	575	58,803		58,803	(745)	58,058			11
12	Social Services	38,658			38,658		38,658		38,658			12
13	Nurse Aide Training											13
14	Program Transportation			1,289	1,289	723	2,012		2,012			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,516,223	131,996	25,022	1,673,241	723	1,673,964	(745)	1,673,219			16
	C. General Administration											
17	Administrative	73,064			73,064		73,064	82,483	155,547			17
18	Directors Fees											18
19	Professional Services			179,418	179,418		179,418	(153,115)	26,303			19
20	Dues, Fees, Subscriptions & Promotions			36,574	36,574		36,574	(24,126)	12,448			20
21	Clerical & General Office Expenses	34,775	17,724	18,679	71,178		71,178	7,064	78,242			21
22	Employee Benefits & Payroll Taxes			312,292	312,292		312,292	13,135	325,427			22
23	Inservice Training & Education			1,442	1,442		1,442		1,442			23
24	Travel and Seminar			3,294	3,294		3,294	2,746	6,040			24
25	Other Admin. Staff Transportation			1,446	1,446	(723)	723	3,198	3,921			25
26	Insurance-Prop.Liab.Malpractice			61,683	61,683		61,683	235	61,918			26
27	Other (specify):* See Attached Sch VI			28,586	28,586		28,586	(28,586)				27
28	**TOTAL General Administration**	107,839	17,724	643,414	768,977	(723)	768,254	(96,966)	671,288			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,957,764	390,590	799,119	3,147,473		3,147,473	(99,955)	3,047,518			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shelbyville Manor #0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			35,235	35,235		35,235	90,462	125,697			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			851	851		851	93,426	94,277			32
33	Real Estate Taxes			86,742	86,742		86,742	287	87,029			33
34	Rent-Facility & Grounds			319,902	319,902		319,902	(315,993)	3,909			34
35	Rent-Equipment & Vehicles			1,750	1,750		1,750	656	2,406			35
36	Other (specify):* **Amortization**							2,820	2,820			36
37	**TOTAL Ownership**			444,480	444,480		444,480	(128,342)	316,138			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			7,775	7,775		7,775		7,775			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,723	71,723		71,723		71,723			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			79,498	79,498		79,498		79,498			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,957,764	390,590	1,323,097	3,671,451		3,671,451	(228,297)	3,443,154			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,085)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,073	30		9
10	Interest and Other Investment Income	(45,568)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(951)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,586)	27		24
25	Fund Raising, Advertising and Promotional	(23,688)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(452)	20		28
29	Other-Attach Schedule See Attached Schedule VII	(1,911)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (97,168)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense		31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(131,129)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (131,129)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (228,297)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Shelbyville Manor

ID# 0038570

Report Period Beginning: 1/1/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,036)	0	0	0	0	0	0	0	0	0	0	(3,036)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,036)	0	0	0	0	0	0	0	0	0	0	(3,036)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(34,230)	0	0	0	0	0	0	0	0	0	(34,230)	19
20	Fees, Subscriptions & Promotions	(24,140)	0	0	0	0	0	0	0	0	0	0	(24,140)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(28,586)	0	0	0	0	0	0	0	0	0	0	(28,586)	27
28	**TOTAL General Administration**	(52,726)	(34,230)	0	0	0	0	0	0	0	0	0	(86,956)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(55,762)	(34,230)	0	0	0	0	0	0	0	0	0	(89,992)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Shelbyville Manor** **#** **0038570** **Report Period Beginning:** **1/1/01** **Ending:** **12/31/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	6,073	0	0	0	0	0	0	0	0	0	0	6,073	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(45,568)	0	0	0	0	0	0	0	0	0	0	(45,568)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(96,899)	0	0	0	0	0	0	0	0	0	(96,899)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(39,495)	(96,899)	0	0	0	0	0	0	0	0	0	(136,394)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(95,257)	(131,129)	0	0	0	0	0	0	0	0	0	(226,386)	45

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illini Manors, Inc.	100%	See Attached Schedule I		RFMS, Inc.	Galesburg	Admin. Svcs.
(100% owned by Don Fike)						
				L B Properties, Inc.	Galesburg	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	34	Facility Rental	319,902	L B Properties, Inc.	None	223,003	(96,899)	2
3	V				(77.6% owned by Don Fike)				3
4	V								4
5	V	19	Administrative Services	156,000	RFMS, Inc.	None	121,770	(34,230)	5
6	V				(100% owned by Don Fike)				6
7	V								7
8	V								8
9	V				See Attached Schedules III and IV				9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 475,902			$ 344,773	$ * (131,129)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	Don Fike	President	Management	100.00	See Attached	>40	100.00	Salary	8,686	17-7	2
3					Schedule III			Benefits	585	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,271		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	Bank One, Springfield		x	Refinanced building mortgage	Varies Pd	05/09/96	2,624,827	1,986,007	04/01/11	6.6600	138,843	2
3					Quarterly							3
4	Interest Income Adjustment			From page 5, line 10							(45,568)	4
5												5
	Working Capital											
6												6
7	Miscellaneous Vendors		x	Miscellaneous operating							851	7
8	Home Office Allocation Adj.			See Attached Schedule III							151	8
9	TOTAL Facility Related						$ 2,624,827	$ 1,986,007			$ 94,277	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,624,827	$ 1,986,007			$ 94,277	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$ 58,560	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 69,202	2
3. Under or (over) accrual (line 2 minus line 1).	$ 10,642	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 76,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 86,742	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	54,603	8
	1997	54,741	9
	1998	56,418	10
	1999	58,560	11
	2000	69,202	12

Real estate tax accrual is based on estimated tax expense. The lessee, by terms of the lease agreement, is required to pay the applicable real estate taxes.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shelbyville Manor COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0038570

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	2013-06-17-305-001	L B Properties Inc	$ 69,202.00	$ 69,202.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,202.00	$ 69,202.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,041 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	6.87 Acres	1991	$ 20,000	1
2					2
3	TOTALS			$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90			1991	$ 991,000	$ 31,460	31	$ 31,460	$	$ 283,140	4
5	41			1992	1,138,566	36,145	31	36,145		325,305	5
6											6
7											7
8											8
	Improvement Type**										
9	Total improvements by year constructed:										9
10	1991			1991	45,000	3,000	15	3,000		27,000	10
11	1992			1992	28,736	1,916	15	1,916		17,244	11
12	1993			1993	2,417		10	242	242	2,017	12
13	1994			1994	47,793	2,652	7-40	1,113	(1,539)	22,475	13
14	1995			1995	2,769	246	7	396	150	2,541	14
15	1997			1997	10,601	734	15	707	(27)	2,887	15
16											16
17	Detailed improvements for the years 1998 - 2001:										17
18	AC condensor			1998	1,522	175	5	304	129	1,165	18
19	Flooring tile			1998	3,390	423	7	484	61	1,855	19
20	Drywall & fire door			1999	17,500	1,169	40	438	(731)	1,059	20
21	Garage			2001	12,648	633	15	492	(141)	492	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,301,942	$ 78,553		$ 76,697	$ (1,856)	$ 687,180	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 764,802	$ 20,699	$ 26,502	$ 5,803	5-15 yrs	$ 715,957	71
72	Current Year Purchases	9,880	1,846	1,287	(559)	5-10 yrs	1,287	72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (See Attached Schedule III)		3,049	3,049				74
75	TOTALS	$ 774,682	$ 25,594	$ 30,838	$ 5,244		$ 717,244	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Ford Enc. Bus	1995	$ 42,500	$	$ 6,071	$ 6,071	7 yrs	$ 36,932	76
77	Patient Care	2000 Ford Bus	2000	48,365	15,477	12,091	(3,386)	4 yrs	16,121	77
78										78
79										79
80	TOTALS			$ 90,865	$ 15,477	$ 18,162	$ 2,685		$ 53,053	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,187,489	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 119,624	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 125,697	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,073	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,457,477	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: L B Properties, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ See Attached			3
4	Additions				Schedule IV -			4
5					Related Party			5
6					Lease			6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE

All nurse aides have met training requirements.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 26,597	$ 107,852	1
2	Cash-Patient Deposits	3,346	3,346	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	445,393	871,188	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,908	101,399	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,574,571	8
9	Other(specify): See Attached Schedule VIII	1,647,680	1,647,680	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,196,924	$ 4,306,036	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		104,078	12
13	Land		20,000	13
14	Buildings, at Historical Cost		2,129,566	14
15	Leasehold Improvements, at Historical Cost	98,640	307,186	15
16	Equipment, at Historical Cost	289,882	1,487,840	16
17	Accumulated Depreciation (book methods)	(285,978)	(2,114,921)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Financing Costs			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 102,544	$ 1,933,749	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,299,468	$ 6,239,785	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 72,569	$ 106,859	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,346	3,346	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	181,702	307,654	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,557	2,557	31
32	Accrued Real Estate Taxes(Sch.IX-B)	76,100	81,986	32
33	Accrued Interest Payable		11,022	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivsion Payable			36
37	Other Accrued Liabilities			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 336,274	$ 513,424	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,986,007	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Resident Security Deposits			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,986,007	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 336,274	$ 2,499,431	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,963,194	$ 3,740,354	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,299,468	$ 6,239,785	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,723,860	1
2	Restatements (describe):		2
3	Year-end adjustments made subsequent to the filing of the		3
4	prior year's Medicaid cost report. (See Attached Schedule IX)	58,765	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,782,625	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	180,569	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 180,569	17
	B. Transfers (Itemize):		
18	Interdivision transfers		18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,963,194	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,802,278	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,802,278	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	38,737	6
7	Oxygen	557	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 39,294	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,341	13
14	Non-Patient Meals	2,085	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,426	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income	745	28
28a	Durable Medical Equipment	3,277	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,022	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,852,020	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	705,255	31
32	Health Care	1,673,241	32
33	General Administration	768,977	33
	B. Capital Expense		
34	Ownership	444,480	34
	C. Ancillary Expense		
35	Special Cost Centers	7,775	35
36	Provider Participation Fee	71,723	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,671,451	40
41	**Income before Income Taxes (line 30 minus line 40)****	180,569	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 180,569	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.** See Attached Schedule V

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,279	1,360	$ 27,205	$ 20.00	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	3,987	4,242	65,198	15.37	3
4	Licensed Practical Nurses	23,639	25,147	315,852	12.56	4
5	Nurse Aides & Orderlies	98,976	105,293	814,970	7.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,592	2,758	104,389	37.85	7
8	Rehab/Therapy Aides	206	219	4,384	20.02	8
9	Activity Director	1,488	1,583	14,245	9.00	9
10	Activity Assistants	4,934	5,249	42,152	8.03	10
11	Social Service Workers	3,320	3,532	38,658	10.95	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,664	24,110	163,709	6.79	15
16	Dishwashers					16
17	Maintenance Workers	2,025	2,155	30,705	14.25	17
18	Housekeepers	12,384	13,174	91,165	6.92	18
19	Laundry	7,146	7,602	48,123	6.33	19
20	Administrator	1,955	2,080	49,601	23.85	20
21	Assistant Administrator	1,955	2,080	23,463	11.28	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,715	2,888	34,775	12.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,480	2,638	22,422	8.50	31
32	Other Health C: Supervisors	7,321	7,789	66,748	8.57	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	201,066	213,899	$ 1,957,764 *	$ 9.15	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	***	$ 6,600	1-3	35
36	Medical Director	***	10,900	9-3	36
37	Medical Records Consultant	***	1,640	10-3	37
38	Nurse Consultant	***		10-3	38
39	Pharmacist Consultant	***	1,320	10-3	39
40	Physical Therapy Consultant	***	9,228	10a-3	40
41	Occupational Therapy Consultant	***	0	10a-3	41
42	Respiratory Therapy Consultant	***		10a-3	42
43	Speech Therapy Consultant	***	0	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) Dental Consultant	***	70	10-3	46
47	Psychological Consultant	***		10-3	47
48	***=Monthly Fee Arrangement				48
49	TOTAL (lines 35 - 48)		$ 29,758		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Glenna Taylor	Administrator	None	49,601
Kimbery Weltow	Asst. Admin.	None	23,463
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,064

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
RFMS, Inc.	Administrative Services	156,000
McGladrey & Pullen, LLP	Accounting Services	11,703
Systematic Management	Collections Consultant	11,665
Brown, Hay & Stephens	Legal Fees	50
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 179,418

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,327
Unemployment Compensation Insurance	22,689
FICA Taxes	147,474
Employee Health Insurance	84,188
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Plan Contributions	9,921
Other Employment Benefits	3,359
Employee Appreciation	334
Indirect Costs - See Attached Sch. III	13,135
TOTAL (agree to Schedule V, line 22, col.8)	$ 325,427

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	1,955
Health Care Worker Background Check	1,512
(Indicate # of checks performed 126)	
IHCA Dues	6,488
Subscriptions & Fees	1,018
Other Licenses	1,061
Advertising - Promotional	23,688
Advertising - Yellow Pages	452
Indirect Costs - See Attached Sch III	14
Less: Public Relations Expense	( )
Non-allowable advertising	(23,688)
Yellow page advertising	(452)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,448

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility	
business and meals (under $250 per	975
travel voucher)	
Seminar Expense	2,319
Less out-of-state training	(1,166)
Indirect Costs - See Attached Sch. III	3,912
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,040

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2	None												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See page 21, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,718** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **71,723**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,085**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey & Pullen, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not yet completed.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

FACILITY NAME: Shelbyville Manor YEAR ENDED: 12/31/01

COST REPORT GROUPINGS
DATA INPUT SHEET

Cost Center	Cost Type	Grouping Code	$ Amount
Dietary	Labor	1-1	163,709
Dietary	Supplies	1-2	17,406
Dietary	Other	1-3	6,600
Nursing	Labor	10-1	1,312,395
Nursing	Supplies	10-2	130,165
Nursing	Other	10-3	3,030
Therapy	Labor	10A-1	108,773
Therapy	Other	10A-3	9,228
Activities	Labor	11-1	56,397
Activities	Supplies	11-2	1,831
Activities	Other	11-3	575
SocSerDir	Labor	12-1	38,658
SocSerDir	Other	12-3	0
NurseAideTrng	Labor	13-1	0
NurseAideTrng	Supplies	13-2	0
NurseAideTrng	Other	13-3	0
ProgramTransp	Other	14-3	1,289
Administrative	Labor	17-1	73,064
Prof. Services	Other	19-3	179,418
FoodPurchase	Supplies	2-2	170,745
Fees,Subs&Promo	Other	20-3	36,574
Clerical&GO	Labor	21-1	34,775
Clerical&GO	Supplies	21-2	17,724
Clerical&GO	Other	21-3	18,679
EmployeeBen	Other	22-3	312,292
Inservice Training	Other	23-3	1,442
Travel	Other	24-3	975
Seminar	Other	24-3a	2,319
Admin Staff Transp	Other	25-3	1,446
Insurance	Other	26-3	61,683
Bad Debts	Other	27-3	28,586
Lobbying	Other	27-3a	0
Housekeeping	Labor	3-1	91,165
Housekeeping	Supplies	3-2	22,113
Housekeeping	Other	3-3	31
Depreciation	Other	30-3	35,235
Amort of Pre-Op	Other	31-3	0
Interest	Other	32-3	851
RealEstateTax	Other	33-3	86,742
Rent-Facility	Other	34-3	319,902
Rent-Equip&Vehicle	Other	35-3	1,750
Amortization	Other	36-3	0
Ancillary	Labor	39-1	0
Ancillary	Other	39-3	7,775
Laundry	Labor	4-1	48,123
Laundry	Supplies	4-2	13,553
Vending	Other	41-3	0
ProvParticFee	Other	42-3	71,723
Utilities	Other	5-3	95,482
Maintenance	Labor	6-1	30,705
Maintenance	Supplies	6-2	17,053
Maintenance	Other	6-3	28,570
MedicalDirector	Other	9-3	10,900

Balance Sheet	Grouping Code	$ Amount
Cash	A1	26,597
Patient Deposits	A2	3,346
Accounts Receivable	A3	445,393
Prepaid Insurance	A6	73,908
Other Prepaid Exp	A7	0
Related Party Rec'ble	A8	0
Interdivision Receivable	A9	1,647,680
Interest Receivable	A9a	0
Long-Term Investments	B12	0
Land	B13	0
Buildings	B14	0
Leasehold Improve	B15	98,640
Equipment	B16	289,882
Accum Depreciation	B17	(285,978)
Deferred Maintenance	B18	0
Org & Pre-Op Costs	B19	0
Accum Amortization	B20	0
Loan Financing Costs	B23a	0
Leasehold Deposit	B23b	0
Total Assets		2,299,468
Accounts Payable	C26	72,569
A/P-Patient Deposits	C28	3,346
Accrued Salaries	C30	181,702
Accrued Taxes	C31	2,557
AccrRealEstateTax	C32	76,100
Accrued Interest	C33	0
Interdivision Payable	C36	0
Other Current Liab	C37	0
Mortgage Payable	D40	0
Security Deposits	D44	0
Retained Earnings	E1	1,782,625
Distributions	E13	0
Transfers	E18	0
Total Liab & Equity		2,118,899
Net Income(Loss)		**180,569**
Ending RE		**1,963,194**
Gross Revenue	R1	3,802,278
NurseAideTrngReimb	R11	0
Vending	R12	0
Barber & Beauty	R13	4,341
Non-Patient Meals	R14	2,085
Telephone & TV	R15	0
Non-Patient Supplies	R18	0
Contributions	R24	0
Interest	R25	0
Recoveries	R28	745
Durable Med Equip	R28a	3,277
Gain(loss)-equipment	R28b	0
Outpatient Services	R5	0
Therapy	R6	38,737
Oxygen	R7	557
Income Tax (expense)	R42	0
Total Revenue		3,852,020
Total Costs		3,671,451
Net Income(Loss)		**180,569**
Input Error (s/b -0-)		**0**

FACILITY NAME: Shelbyville Manor **YEAR ENDED:** 12/31/01

OTHER INFORMATION DATA INPUT SHEET

Sales Tax			951
(Grouping Code 2-2 a/c # 9850 - Sales Tax)			
Diaper Expense			6,718
(Grouping Code 10-2 a/c # 4115 - Incontinence)			
Prior Year Ending Equity		0	1,723,860
(page 17, line 47)		var	
Prior Year Accrued Real Estate Tax			58,560
(page 17, line 32)			
Amount of Note - Original			2,624,827
(prior year page 9, column 6)			
Accrued Employee Time	**Ending**		75,013
(Grouping Code C30, a/c # 1715)	**Beginning**		77,877
Vehicle Expense			1,404
(Grouping Code 25-3 a/c # 9305)			
Interdivsion Transfers		0	0
		var	
Shareholder Distributions		0	0
		var	
MEDICARE BEDS	**Ending**		13
CENSUS INFORMATION (beds)	**Beginning**		131
	Ending		131

Beginning Equity Adjustments	
Uncollectible patient accounts	0
Medicare cost report settlements	0
Related party accrued interest income	0
Workers' comp insurance	58,765
Miscellaneous	0
Illinois replacement tax	0
Net Prior Period Adjustments	58,765

Tax Return Info			
Meals expenses:	**14-3**		185
(by grouping code)	**23-3**		0
	24-3		268
	24-3a		284
50% tax limitation =	**369**		737
Tax depreciation expense			33,737
Capital Lease Depreciation			81,340
Fines and Penalties			0
Out-of-State Training			1,166

Real Estate Tax History		
(prior year page 10)	**1995**	54,603
	1996	54,741
	1997	56,418
1999 tax payments	69,202	**1998** 58,560
(per tax bill) var	0	

		SALARY COSTS		**Page 20 Line/Amt**	
1,312,395	10-1	4000	27,205	1	27,205
0		4005	0	2	0
var		4006	38,008	32	66,748
		4007	5,660	32	
		4008	22,422	31	22,422
		4010	60,238	3	65,198
		4011	4,960	3	
		4015	281,602	4	315,852
		4016	34,250	4	
		4018	253	32	
		4020	531,689	5	814,970
		4021	22,827	32	
		4022	148,312	5	
		4023	29,480	5	
		4024	86,667	5	
		4025	14,882	5	
		4026	3,940	5	
108,773	10A-1	4050	47,564	7	104,389
0		4051	2,005	8	4,384
		4052	0	8	
		4055	52,130	7	
		4056	2,379	8	
		4060	4,695	7	
56,397	11-1	2000	14,245	9	14,245
0		2005	42,152	10	42,152
73,064	17-1	8000	49,601	20	49,601
0		8005	23,463	21	23,463
	Total		**1,550,629**		**1,550,629**

		CONSULTANT SERVICES			**Pg 20. Ln/Amt**
3,030	10-3	4400	1,320	39	1,320
0		4425	70	46	70
		4455	1,640	37	1,640
9,228	10A-3	4550	0	40	9,228
0		4551	0	40	
		4552	0	40	
		4575	0	41	0
		4576	0	41	
		4577	0	41	
		4600	0	43	0
		4601	0	43	
		4602	0	43	
		4650	9,228	40	
	Total		**12,258**		**12,258**

CENSUS INFORMATION (days)	
Private Skilled	1,466
Paid Bedhold	5
Non-paid Bedhold	0
Paid Discharge	0
Private Intermediate	10,543
Paid Bedhold	162
Non-paid Bedhold	0
Paid Discharge	0
Private Other	3,634
Paid Bedhold	14
Paid Discharge	0
Sheltered Care	0
Paid Bedhold	0
Paid Discharge	0
Medicare	2,712
Paid Bedhold	0
Non-paid Bedhold	0
Paid Discharge	0
Medicaid	18,814
Paid Bedhold	8
Non-paid Bedhold	0
Paid Discharge	0
V.A. days	0
Total Days	**37,358**

CENSUS SUMMARY	
Private Skilled	**5,100**
Private Intermediate	**10,543**
Sheltered Care	**0**
Medicare	**2,712**
Medicaid	**18,814**
V.A.	**0**
Total Patient Days	**37,169**
Bed hold Days	**189**
Total Days	**37,358**
Medicaid Allocation:	
Skilled (1/3)	**6,271**
Intermediate (2/3)	**12,543**
Medicaid Paid Bedhold	**8**

FACILITY NAME: **Shelbyville Manor** BEGINNING: **1/1/01**

ID#: **0038570** ENDING: **12/31/01**

RELATED PARTIES DATA INPUT SHEET

1	Balance Sheet	Grouping Code	Facility $ Amount	RFMS Mngmnt Amount	Lessor Amount	Consoli-dated Total
	Cash	A1	26,597	81,255	0	107,852
	Patient Deposits	A2	3,346	0	0	3,346
	Accounts Receivable	A3	445,393	425,795	0	871,188
	Prepaid Insurance	A6	73,908	27,491	0	101,399
	Other Prepaid Exp	A7	0	0	0	0
	Related Party Rec'ble	A8	0	1,574,571	0	1,574,571
	Interdivision Receivable	A9	1,647,680	0	0	1,647,680
	Interest Receivable	A9a	0	0	0	0
	Long-term Investments	B12	0	104,078	0	104,078
	Land	B13	0	0	20,000	20,000
	Buildings	B14	0	0	2,129,566	2,129,566
	Leasehold Improve	B15	98,640	134,810	73,736	307,186
	Equipment	B16	289,882	622,295	575,663	1,487,840
	Accum Depreciation	B17	(285,978)	(601,776)	(1,227,167)	(2,114,921)
	Deferred Maintenance	B18	0	0	0	0
	Org & Pre-Op Costs	B19	0	0	0	0
	Accum Amortization	B20	0	0	0	0
	Loan Financing Costs	B23a	0	0	0	0
	Leasehold Deposit	B23b	0	0	0	0
	Total Assets		2,299,468	2,368,519	1,571,798	6,239,785
	Accounts Payable	C26	72,569	34,290	0	106,859
	A/P-Patient Deposits	C28	3,346	0	0	3,346
	Short-Term Notes Pay	C29	0	0	0	0
	Accrued Salaries	C30	181,702	125,952	0	307,654
	Accrued Taxes	C31	2,557	0	0	2,557
	AccrRealEstateTax	C32	76,100	5,886	0	81,986
	Accrued Interest	C33	0	0	11,022	11,022
	Interdivision Payable	C36	0	0	0	0
	Other Current Liab	C37	0	0	0	0
	Mortgage Payable	D40	0	0	1,986,007	1,986,007
	Patient Deposits	D44	0	0	0	0
	Retained Earnings	E1	1,782,625	2,202,391	(425,231)	3,559,785
	Distributions	E13	0	0	0	0
	Transfers	E18	0	0	0	0
	Total Liab & Equity		2,118,899	2,368,519	1,571,798	6,059,216
	Net Income(Loss)		**180,569**	**0**	**0**	**180,569**

2		
	Lessor - Interest Expense	138,843
	Lessor - Loan Fee Amortization	2,820

FACILITY NAME:	**Shelbyville Manor**	**BEGINNING:**	**1/1/01**
ID #:	**0038570**	**ENDING:**	**12/31/01**

ATTACHED SCHEDULE I

VII. RELATED NURSING HOMES

FACILITY NAME	CITY
Care Center of Abingdon	Abingdon
Centralia Manor	Centralia
Jerseyville Manor	Jerseyville
Lawrenceville Manor	Lawrenceville
Leroy Manor	Leroy
Maryville Manor	Maryville
Parkway Manor	Marion
Pekin Manor	Pekin
Pittsfield Manor	Pittsfield
Seminary Manor	Galesburg
Shelbyville Manor	Shelbyville

RECLASSIFICATION ENTRY	Schedule and Line #	Total Per General Ledger (Column 4)	Reclass Increase or (Decrease) (Column 5)	Reclassified Total (Column 6)
(1)				
To Allocate a % of Vehicle Expenses To Program				
Program Transportation	**V-14**	**1,289**	**723**	**2,012**
Other Admin. Staff Transportation	**V-25**	**1,446**	**(723)**	**723**

SCHEDULE V - LINE 25 - OTHER ADMIN. STAFF TRANSPORTATION

Care Related Vehicle Expenses:	
Fuel and miscellaneous supplies	**1,404**
Repairs and maintenance	**42**
Total vehicle expenses	**1,446**

FACILITY NAME:	Shelbyville Manor	**BEGINNING:**	1/1/01
ID #:	0038570	**ENDING:**	12/31/01

ATTACHED SCHEDULE II **Bed Allocation**

FACLITY NAME:	**Shelbyville Manor**	**BEGINNING:**	**1/1/01**
ID#:	**0038570**	**ENDING:**	**12/31/01**

ATTACHED SCHEDULE III **Allocation of Related Party Administrative Service Costs**

SUMMARY SCHEDULE

(See attached detail schedule)

Sch. V Line #		Salaries	Other	Total
1	Dietary			0
2	Food Purchase			0
3	Housekeeping			0
4	Laundry			0
5	Heat & Other Utilities		325	325
6	Maintenance		467	467
7	Other			0
9	Medical Director			0
10	Nursing & Med Records			0
10A	Therapy			0
11	Activities			0
12	Social Services			0
13	Nurse Aide Training			0
14	Program Transportation			0
15	Other			0
17	Administrative	82,483		82,483
18	Directors Fees			0
19	Professional Services		2,885	2,885
20	Fees, Subs. & Pro.		14	14
21	Clerical & General		7,064	7,064
22	Employee Ben. & P/R		13,135	13,135
23	Inservice Training & Ed.			0
24	Travel & Seminar		3,912	3,912
25	Admin. Staff Transp.		3,198	3,198
26	Insurance		235	235
27	Other			0
30	Depreciation		3,049	3,049
31	Amortization of Pre-Op.			0
32	Interest		151	151
33	Real Estate Taxes		287	287
34	Rent-Facility & Grounds		3,909	3,909
35	Rent-Equip. & Vehicles		656	656
36	Other - Amortization			0
	TOTALS	82,483	39,287	121,770

19	Amount per G/L - administrative services recorded as professional fees	(156,000)
	Net adjustment required	(34,230)

FACLITY NAME:	**Shelbyville Manor**	**BEGINNING:**	**1/1/01**
ID#:	**0038570**	**ENDING:**	**12/31/01**

ATTACHED SCHEDULE III **Allocation of Related Party Administrative Service Costs**

DETAIL SCHEDULE

ALLOCATION FACTORS	Total Y-T-D Beds	Facility Y-T-D Beds	Allocation Percentage
ALL FACILITIES	**33,156**	**1,440**	**4.3431%**
NURSING HOME FACILITIES	**16,128**	**1,440**	**8.9286%**

	Total Costs Incurred	Non-Allowable Costs	Adjusted Costs	Allocated Costs	Schedule & Line Reference
ALL FACILITIES:					
Salaries - Owner	200,000		200,000	8,686	V-17
Salaries and wages	816,159	49,212	766,947	33,309	V-17
Advertising	317		317	14	V-20
Insurance	5,401		5,401	235	V-26
Payroll taxes & other benefits - Owner	37,441	23,970	13,471	585	V-22
Payroll taxes & other benefits	156,214	10,580	145,634	6,325	V-22
Utilities	8,579	1,089	7,490	325	V-5
Telephone	35,472		35,472	1,541	V-21
Building rental	90,000		90,000	3,909	V-34
Depreciation	70,200		70,200	3,049	V-30
Interest	3,481		3,481	151	V-32
Legal fees	13,898	6,364	7,534	327	V-19
Accounting fees	92,167	50,765	41,402	1,798	V-19
Outside management consutants	17,500		17,500	760	V-19
Supplies	100,911		100,911	4,383	V-21
Airplane & vehicle rental	15,098		15,098	656	V-35
Vehile expense	15,156		15,156	658	V-25
Travel reimbursements	38,443	34,103	4,340	188	V-24
Meal expense	15,657	8,137	7,520	327	V-24
Training	4,985	2,350	2,635	114	V-24
Real estate taxes	6,612		6,612	287	V-33
Building & equipment maintenance	10,752		10,752	467	V-6
Other	28,403	28,403	0	0	V-21
Printing	4,030	48	3,982	173	V-21
SUBTOTALS	1,786,876	215,021	1,571,855	68,267	
NURSING HOME FACILITIES:					
Salaries and wages	453,471		453,471	40,488	V-17
Insurance	0		0	0	V-26
Payroll taxes & other benefits	69,718		69,718	6,225	V-22
Telephone	10,835		10,835	967	V-21
Vehicle expense	28,445		28,445	2,540	V-25
Vehicle lease	0		0	0	V-35
Travel reimbursements	21,672		21,672	1,935	V-24
Meal expense	2,792		2,792	249	V-24
Training	12,306		12,306	1,099	V-24
SUBTOTALS	599,239	0	599,239	53,503	
TOTALS	2,386,115	215,021	2,171,094	121,770	

SUMMARY SCHEDULE

Salaries - Administrative	**82,483**	**V-17**
Heat & Other Utilities	**325**	**V-5**
Maintenance	**467**	**V-6**
Professional Services	**2,885**	**V-19**
Fees, Subscriptions & Promotion	**14**	**V-20**
Clerical & General Office Exp.	**7,064**	**V-21**
Employee Benefits & P/R Taxes	**13,135**	**V-22**
Travel & Seminar	**3,912**	**V-24**
Other Admin. Staff Transp.	**3,198**	**V-25**
Insurance	**235**	**V-26**
Depreciation	**3,049**	**V-30**
Interest	**151**	**V-32**
Real Estate Taxes	**287**	**V-33**
Rent - Facility	**3,909**	**V-34**
Rent - Equipment & Vehicles	**656**	**V-35**
	39,287	
	121,770	

FACILITY NAME: Shelbyville Manor BEGINNING: 1/1/01
ID#: 0038570 ENDING: 12/31/01

ATTACHED SCHEDULE IV Related Party Cost Adjustment
Facility Rent

Cost to Related Party Lessor:			
Depreciation (Reported on Sch. XI)	81,340		V-30
Interest	138,843		V-32
Loan Fee Amortization	2,820		V-36
Total lessor cost		223,003	
Cost Per General Ledger - Facility Rent		319,902	V-34
Cost Adjustment Required		(96,899)	

Page 5, Line 10, Interest and Other Investment Income Adjustment

Allocation of Investment Income
(Centralia Manor a/c #1929 & 1930)

Facility	Beds/Units	%	Allocated	Adjust
Centralia Manor	120	9.4637%	41,742	
Jerseyville Manor	84	6.6246%	29,219	
Lawrenceville Manor	123	9.7003%	42,786	
Leroy Manor	96	7.5710%	33,394	
Maryville Manor	120	9.4637%	41,742	
Parkway Manor	119	9.3849%	41,394	
Pekin Manor	151	11.9085%	52,525	
Pittsfield Manor	105	8.2808%	36,524	
Shelbyville Manor	131	10.3312%	45,568	45,568
Centralia Estates	39	3.0757%	13,566	
Liberty Estates	59	4.6530%	20,523	
Parkway Estates	42	3.3123%	14,610	
Pekin Estates	79	6.2303%	27,480	
Totals	1,268	100%	441,074	

Interest and Other Investment Income (Page 19, Line 25)	0
Required Adjustment (Page 5, Line 10)	45,568

FACILITY NAME:	Shelbyville Manor	**BEGINNING:**	1/1/01
ID #:	0038570	**ENDING:**	12/31/01

ATTACHED SCHEDULE V

PAGE 19, XVII. INCOME STATEMENT

Federal Income Tax Return Reconciliation:

Income (loss) before income taxes (Line 41)		**180,569**
Nondeductible expenses:		
50% meal exclusion	**369**	
Fines and penalties	**0**	
Lobbying expenses	**0**	
		369
Timing differences:		
Depreciation expense - tax basis	**(33,737)**	
Depreciation expense - book basis	**35,235**	
Accrued vacation exp. - prior year	**(77,877)**	
Accrued vacation exp. - current year	**75,013**	
		(1,366)
Taxable income (loss)		**179,572**

FACILITY NAME: Shelbyville Manor BEGINNING: 1/1/01
ID#: 0038570 ENDING: 12/31/01

ATTACHED SCHEDULE VI

SCHEDULE V - COST CENTER EXPENSES
LINE 27 - OTHER:

Bad Debts	28,586
Lobbying	0
Total	28,586

ATTACHED SCHEDULE VII

SCHEDULE VI - ADJUSTMENT DETAIL
LINE 29 - OTHER:

Out-of-state Training	V-24	1,166
Lobbying	V-27	0
Activity fund income	V-11	745
Total		1,911

ATTACHED SCHEDULE VIII

Page 17, XV. BALANCE SHEET

	Operating	After Consolidated
Line 9, Other Current Assets:		
Interdivision Receivable	1,647,680	1,647,680
Interest Receivable	0	0
Total	1,647,680	1,647,680

ATTACHED SCHEDULE IX

Page 18, XVI. STATEMENT OF CHANGES IN EQUITY

Line 4, Restatements:

Uncollectible patient accounts	0
Medicare cost report settlements	0
Related party accrued interest income	0
Workers' comp insurance	58,765
Miscellaneous	0
Illinois replacement tax	0
Total	58,765

Restatements are year end adjustments which were made subsequent to the preparation of the Medicaid cost report for the prior year. The equity balance at the beginning of the year, restated by the above adjustments, agrees with the financial statements.

FACILITY NAME:	Shelbyville Manor	**BEGINNING:**	1/1/01
ID#:	0038570	**ENDING:**	12/31/01